No. 04-(1)

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

SHIRLEY O. FOUGHT,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Tenth Circuit's decision, which irrebuttably presumes a conflict of interest from an insurance company's dual roles as funding source and ERISA claim fiduciary, and then shifts the burden to the insurer to defend its denial of benefits, exacerbates already great conflicts among the circuits and violates ERISA and the terms of ERISA-governed plans that grant discretion to insurers to determine claims, thereby eviscerating the arbitrary and capricious standard of review that this Court held applicable to discretionary benefits determinations in *Firestone*.

PARTIES TO THE PROCEEDING

Shirley O. Fought was the plaintiff in the district court and the appellant in the Tenth Circuit. UNUM Life Insurance Company of America was the defendant in the district court and the appellee in the Tenth Circuit.

RULE 29.6 DISCLOSURE STATEMENT

UNUM Life Insurance Company of America is a wholly-owned indirect subsidiary of UnumProvident Corporation, which is a publicly-traded corporation.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner UNUM Life Insurance Company of America ("UNUM") respectfully petitions this Court for a writ of certiorari to review the decision of the United States Court of Appeals for the Tenth Circuit, in order to provide direction on a critical and recurring question under the Employee Retirement Income Security Act of 1974 ("ERISA") as to which the courts of appeals are hopelessly at odds: The appropriate standard of review of an ERISA fiduciary's denial of benefits when (a) the plan vests the fiduciary with discretion, and (b) the fiduciary is an insurance company that also funds the plan through an insurance policy. The Court addressed this issue in a single sentence in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989): "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is oper-

ating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* at 115 (quoting Restatement (Second) of Trusts § 187, comment d (1959)). In the ensuing fifteen years, the lower federal courts have struggled mightily to give effect to that statement, with confused, inconsistent, and in some instances—including the Tenth Circuit's decision in this case—illogical results that contradict the trust law principles underlying ERISA.

It is important that the Court exercise certiorari jurisdiction in this case. The Tenth Circuit held that an ERISA claim fiduciary that also serves as the third-party insurer for the plan has an inherent and irrebuttable conflict of interest. It further held that in cases reviewing denials of benefits by such inherently-conflicted fiduciaries, the burden of proof shifts to the insurer to affirmatively demonstrate that its denial was supported by substantial evidence. The Tenth Circuit's decision rests on the inaccurate and unfair presumption that whenever an insurer is both fiduciary and payor, those dual roles alone necessarily taint the carrier's resolution of claims. That presumption of bias is inconsistent with ERISA, which permits a fiduciary to serve as the plan's funding source. It also strips insurer fiduciaries of the very discretion that the Court held protected in *Firestone*.

Moreover, the Tenth Circuit is the first court of appeals to irrebuttably presume an actual conflict solely by virtue of an insurer's two roles. The decision conflicts with decisions of other circuits—which are themselves in conflict—and injects further discord into an area of the law that is already rife with confusion. This is an apt juncture for the Court to clarify for the lower courts, employers, fiduciaries, and claimants what the Court meant in that single sentence in *Firestone*.

Petitioner asks the Court to hold that (1) standing alone, an insurer's service as both fiduciary and payor does not affect the arbitrary and capricious standard of review, (2) the

burden is on the claimant to prove an actual conflict that improperly motivated the insurer's denial of benefits, and (3) a proven actual conflict should be considered as a factor in applying the still-controlling arbitrary and capricious standard of review, as the Court instructed in *Firestone*. This holding will achieve uniformity in the enforcement of ERISA; it will conform to commercial realities, in which insurers strive to meet their fiduciary obligations under ERISA and have little, if anything, to gain by denying meritorious claims; it will give insurer fiduciaries the necessary latitude to exercise their plan-granted discretion; and it will further Congress' objective of encouraging employers to provide ERISA benefit plans.

OPINIONS BELOW

The district court's unpublished memorandum opinion, dated May 31, 2002, is reproduced in the Appendix to this petition ("App.") at 70a. The initial opinion of the Tenth Circuit is reproduced at App. 33a. The substituted panel decision is reported at 379 F.3d 997 and reproduced at App. 1a.

JURISDICTION

The original judgment of the Tenth Circuit was entered on February 6, 2004. UNUM petitioned for rehearing and rehearing en banc. The panel granted rehearing and issued a substitute decision that was entered on August 13, 2004. The Tenth Circuit invited a renewed petition for rehearing en banc but denied UNUM's timely petition on October 26, 2004. Petitioners invoke the jurisdiction of this Court under 28 U.S.C. § 1254(1) (2000).

STATUTORY PROVISIONS INVOLVED

Section 404(a)(1) of ERISA, 29 U.S.C. § 1104(a)(1) (2000), defines fiduciary duties under the Act. Under Section 502(a) of the Act, *id.*, § 1132(a), a plan participant may bring a civil

action to redress a fiduciary's breach of its responsibilities. Relevant portions of these statutory provisions are set forth at App. 81a and App. 82a.

STATEMENT OF THE CASE

Factual Background. In May 1998, Ms. Fought enrolled for coverage under her employer's new disability benefits plan. Plan benefits were funded by a group policy of long-term disability insurance that UNUM had issued to the employer.

The plan designates UNUM as the claim administrator and gives UNUM discretionary authority to construe the terms and provisions of the plan and to determine claims. Court of Appeals Appellee's Supplemental Appendix ("C.A. Supp. App.") 329. The plan includes a pre-existing condition provision that applies to conditions that existed within three months before the employee's participation in the plan, and that excludes coverage for disabilities beginning in the first twelve months of coverage that were "caused by, contributed to by, or resulting from" any pre-existing condition. *Id.* at 341-42.

When Ms. Fought enrolled in the plan, she had a pre-existing condition as defined under the plan, because on March 16, 1998 (within three months before the effective date of her coverage), she had been diagnosed with various ailments, including a cardiac condition. In August 1998 she underwent angioplasty surgery, in March 1999 she underwent heart bypass surgery, and within weeks of the second surgery she developed a staph infection at the site of the incision. All of these medical events occurred in the first twelve months of coverage.

In June 1999, Ms. Fought applied for long-term disability benefits. All of her initial submissions to UNUM (the employer statement, employee statement, and attending physician's statement) stated that her disability began on varying

dates in March 1999, when the bypass surgery occurred. C.A. Supp. App. at 234, 242, 257. Those submissions identified the cause of her disability as "coronary artery disease," "heart attack," or "open heart surgery"—not the related staph infection. *Id.*

Because the disability began during the first year of coverage and was caused by Ms. Fought's cardiac condition, which had been diagnosed fewer than three months before the coverage took effect, UNUM denied her claim under the plan's pre-existing condition exclusion. Ms. Fought appealed and contended that the staph infection was a separate and unrelated cause of her disability. Even then, one of her doctors concluded that she was "totally disabled due to her heart condition." Court of Appeals Appellant's Appendix 154. (Ms. Fought falsified that doctor's report by deleting the words "due to her heart condition" when she submitted the document to UNUM in support of her appeal. *Id.* at 143-44.)

UNUM adhered to its original denial because, under its reading of the pre-existing condition exclusion, it perceived the staph infection as sufficiently related to the heart surgery to fall under that provision.

Proceedings Below. In challenging UNUM's denial of benefits, Ms. Fought invoked the jurisdiction of the district court under 29 U.S.C. § 1132(a)(1)(B) (2000) and 28 U.S.C. § 1331 (2000). Section 1132(a)(1)(B) provides a cause of action for a plan participant like Ms. Fought to "recover benefits due to [her] under the terms of [her] plan, to enforce [her] rights under the terms of the plan, or to clarify [her] rights to future benefits under the terms of the plan." The district court resolved the case on summary judgment.

Because the plan confers discretionary authority on UNUM, the district court began its analysis with the arbitrary and capricious standard of review under *Firestone*. App. 74a. However, the district court applied a "sliding scale abuse of

discretion" standard of review because, under prevailing law in the Tenth Circuit, UNUM was deemed to have an "inherent" conflict of interest merely by virtue of its dual role as claim fiduciary and payor of benefits. *Id.* at 74a-75a. The court concluded that UNUM did not abuse its discretion in construing the expansive language in its pre-existing condition provision as extending to both Ms. Fought's heart surgery and the staph infection, which was "a foreseeable complication of treatment." *Id.* at 75a-76a. On that basis, the district court granted summary judgment in favor of UNUM. *Id.* at 77a.

The Tenth Circuit issued two panel decisions. The initial panel decision was vacated on rehearing and replaced by the second decision.

Both the initial and second decisions reversed the district court on the basis that it had not applied the correct standard of review. In the second decision, as in the first, the Tenth Circuit began with these points: (1) Because the plan gives UNUM discretion to determine benefits and interpret the policy's provisions, the district court rightly applied an arbitrary and capricious standard of review, *id.* at 8a-9a; (2) under Tenth Circuit authority, because UNUM is both the claim fiduciary and insurer, it has an apparent conflict that must be weighed as a factor in applying the arbitrary and capricious standard, *id.* at 9a-10a; and (3) the Tenth Circuit has adopted a flexible sliding-scale approach that preserves the deferential review standard but also requires reviewing courts to "'decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict.'" *Id.* at 10a-11a (quoting *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 825 (10th Cir. 1996)).

In both decisions, the Tenth Circuit then pronounced new law by adopting a two-tiered analysis that divides dual-role

claim fiduciaries into two rigid categories. According to the second panel decision:

- *Non-insurer* claim fiduciaries that both self-fund and administer benefit claims under a plan, have a "standard conflict of interest." The claimant must prove that the "standard" (or apparent) conflict is a "serious" (or actual) conflict. If the plaintiff proves an actual conflict, the burden shifts to the non-insurer fiduciary to justify its denial of benefits. Even if the plaintiff fails to prove an actual conflict, the mere apparent conflict is nevertheless considered as a factor that reduces the deference that otherwise would be accorded the conflict-free fiduciary's decision. App. 13a-14a.

- *Insurer* claim fiduciaries like UNUM have an "inherent conflict of interest." In all cases, the Tenth Circuit irrebuttably presumes that the inherent conflict was an actual conflict, and the burden shifts to the insurance company to defend its denial of benefits as supported by substantial evidence. *Id.* at 14a-17a. (In its initial decision, the court had imposed a preponderance of the evidence standard of proof on the insurer. *Id.* at 46a-50a. In response to UNUM's petition for rehearing, the panel abandoned this standard and substituted the substantial evidence standard.)[1]

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[1] In dictum, the Tenth Circuit extended its shifted-burden analysis to yet another circumstance, *i.e.*, "when a serious procedural irregularity exists." *Id.* at 14a. Without attempting to define such an irregularity, the court found "no question" that one existed in this case based on UNUM's failure to have ordered an independent medical examination ("IME"). *Id.* at 16a, 31a-32a. The court ignored the essentially undisputed medical fact that Ms. Fought developed a staph infection as a complication of surgery for a pre-existing coronary condition. The only issue was whether UNUM abused its discretion in concluding that the plan's pre-existing condition provision applied to those facts. An IME would not have had any bearing on UNUM's interpretation of its policy language. Ironically, within a month of the Tenth Circuit's decision, the Third Circuit reached

In both decisions, the Tenth Circuit relied almost exclusively on the views of a single commentator, whose recommendations do not flow logically from the first 84 pages of her law review article, and whose ultimate conclusions have not been embraced by any other court. *See* Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 Am. U. L. Rev. 1083 (2001) ("Kennedy"), *cited and quoted in* App. 9a, 13a-15a. In the second opinion, the court added as support for its "shifted burden" analysis cases involving exclusionary clauses in insurance policies. *See* App. 16a-17a n.4. But the court showed no sign of limiting its holding to exclusion cases. Rather, the Tenth Circuit an-nounced broad rules to be applied "in instances in which a fiduciary has a conflict of interest," *id.* at 12a, without apparent regard to whether the benefits denial rested on a coverage provision or an exclusion. In denying rehearing en banc, the Tenth Circuit declined UNUM's request that the court narrow its holding to exclusion cases.

Applying its new analysis, the Tenth Circuit repeatedly emphasized UNUM's concession of the existence of a conflict, *id.* at 2a, 6a, 16a, 31a, apparently without understanding that UNUM had admitted only an apparent conflict and had emphatically denied any actual conflict. App. 80a.[2] The court reversed the district court's conclusion that the

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the opposite conclusion, holding that a *request* for an IME constitutes a procedural irregularity that deprives a plan fiduciary of the otherwise applicable arbitrary and capricious standard of review. *See Kosiba v. Merck & Co.*, 384 F.3d 58 (3d Cir. 2004). The defendants in that case, including UNUM, are filing concurrently with this petition a petition for writ of certiorari to review the judgment of the Third Circuit.

[2] UNUM had no choice but to concede an apparent conflict because Tenth Circuit law presumes that an insurer is inherently conflicted. *See Pitman v. Blue Cross & Blue Shield of Okla.*, 217 F.3d 1291, 1296 (10th Cir. 2000). UNUM did not concede that its "inherent" conflict had any impact on the benefit determination, and Ms. Fought presented no evidence of any such impact.

denial of benefits was not arbitrary and capricious. *First*, giving no deference to UNUM's interpretation of the plan language, the Tenth Circuit rejected its application of the pre-existing condition exclusion to complications from treatment of such a condition. *Id.* at 19a-28a. *Second*, although acknowledging "the presence of conflicting evidence in the record" as to the cause of Ms. Fought's disability, the court held that UNUM did not "justif[y] its denial of benefits by substantial evidence." *Id.* at 30a, 32a.

REASONS FOR GRANTING THE WRIT

The Court's terse mandate in *Firestone*, that a fiduciary's conflict "must be weighed as a 'facto[r] in determining whether there is an abuse of discretion,'" 489 U.S. at 115 (citation omitted), has generated volumes of decisions documenting pervasive disagreement over related issues that arise almost daily: (a) The type of conflict—*e.g.*, an "apparent" or "inherent" conflict based on status versus an "actual" conflict—that should reduce the deference otherwise due to ERISA benefit determinations by fiduciaries with discretionary authority; and (b) how courts should "factor" such a conflict into the otherwise applicable arbitrary and capricious standard of review. There is particular disagreement about the application of *Firestone* to the facts in this case: An insurance company's service as both funding source and claim fiduciary, when the plan expressly vests the insurer with discretion.

The Tenth Circuit's decision creates even further conflict among the circuits on the standard of review in civil actions challenging insurer-fiduciaries' claim decisions. Given the prevalence of insured ERISA plans, particularly for small and mid-size employers, this fundamental and important issue arises in hundreds of cases annually. The disparate law at the circuit level disrupts ERISA's uniform enforcement scheme, inevitably leads to forum-shopping, foments litigation, and, ultimately, discourages the provision of ERISA benefits.

Petitioner requests this Court to overturn the Tenth Circuit's decision and resolve the circuit split. The Court should hold that an insurer's role as claim fiduciary, standing alone, has no impact on the otherwise applicable arbitrary and capricious standard of review. The Court also should hold that, even where a claimant proves the existence of an actual conflict, the arbitrary and capricious standard controls, but the actual conflict should be weighed as a factor in applying that standard of review.

I. THERE ARE MASSIVE SPLITS AMONG THE CIRCUITS ON THE ANALYSIS OF DUAL-ROLE CONFLICTS UNDER *FIRESTONE*.

The circuits are in general disagreement as to the meaning of *Firestone's* observation that if a fiduciary exercising discretionary authority under ERISA has a conflict of interest, courts must consider that conflict as a factor in reviewing a denial of benefits for abuse of discretion. The division among the courts of appeals exists on at least two levels: (a) What constitutes a "conflict" under *Firestone*; and (b) how are the courts to "'facto[r]'" that conflict into the otherwise applicable arbitrary and capricious (or abuse of discretion[3])

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[3] In *Firestone*, the Court used "arbitrary and capricious" and "abuse of discretion" interchangeably to describe the alternative to *de novo* review urged by Firestone. *Compare* 489 U.S. at 109 ("[lower] federal courts have adopted the arbitrary and capricious standard" as the appropriate standard under ERISA Section 502), *with id.* at 115 ("conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion'") (citation omitted). Similarly, with the exception of the Fourth and Seventh Circuits, the courts of appeals equate those two standards, treating any distinction between them as "semantic and not substantive." H. Brent McKnight, *Assessing the Impact of Conflict of Interest on the Decisions of ERISA Fiduciaries*, 13 Regent U.L. Rev. 1, 9 n.60 (2001); *see also* Annotation, *Judicial Review of Denial of Health Care Benefits Under Employee Benefit Plans Governed by Employee Retirement Income Security Act (ERISA)* (29 U.S.C.A. § 1132(a)(1)(B))—*Post-Firestone Cases*, 128 A.L.R. Fed. 1, § 29 (1995 & Supp.) (citing cases).

standard of review? This inconsistent body of law, which has become more fractured in the fifteen years since *Firestone*, cries out for clarification from this Court.

A. The Meaning of a Conflict Under *Firestone*.

The circuits fall into two general, but vastly divergent, camps as to when an insurer has a conflict that warrants adjusting the otherwise applicable arbitrary and capricious standard of review.

No presumption of actual conflict. Five courts of appeals—the First, Second, Seventh, Eighth, and Ninth Circuits—require an ERISA claimant to prove an actual or significant conflict before a court will apply less deference to the fiduciary's discretionary determination. Observing that "not every funding conflict of interest per se warrants heightened review," the Eighth Circuit has stated: "To obtain a less deferential review, [a claimant] must present material, probative evidence demonstrating that (1) a palpable conflict of interest . . . existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 & n.2 (8th Cir. 1998) (citation omitted). The Seventh Circuit follows the same approach, presuming that an insurer fiduciary that pays claims out of its own assets "is acting neutrally unless a claimant shows by providing specific evidence of actual bias that there is a significant conflict." *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998). "The existence of a potential [or apparent, structural, financial, or inherent] conflict is not enough." *Id.* *See also Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181, 184 (1st Cir. 1998); *Whitney v. Empire Blue Cross & Blue Shield*, 106 F.3d 475, 477 (2d Cir. 1997) (per curiam); *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1322-23 (9th Cir. 1995).

Applying a law-and-economics rationale, these decisions recognize the forces that keep insurers from acting on their

apparent conflicts in a manner that would be contrary to the interests of plan participants. Insurers face market pressure to pay meritorious claims, at least if they want to retain or gain business. A carrier "can hardly sell policies if it is too severe in administering them." *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999). "Companies . . . who choose which group insurance policies they will use to fund their plans . . . have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims." *Mers*, 144 F.3d at 1021. Because "an employer would not want to keep an overly tight-fisted insurer[, t]he conflict is not as serious as might appear at first blush." *Doyle*, 144 F.3d at 184. In addition, given the large revenues of most insurers, the impact of particular claim denials on an insurer's bottom-line generally will be "not sufficiently substantial to threaten an administrator's impartiality." *Mers*, 144 F.3d at 1020-21.

Rebuttable presumption of actual conflict. Six courts of appeals—the Third, Fourth, Fifth, Sixth, Tenth, and Eleventh Circuits—reach the opposite conclusion, presuming an actual conflict based on the insurer's dual roles alone. The Sixth Circuit has rationalized its approach as follows: "Because an insurance company pays out to beneficiaries from its own assets rather than from the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business . . . ." *Miller v. Metro. Life Ins. Co.*, 925 F.2d 979, 984 (6th Cir. 1991); *but see Carr v. Reliance Standard Life Ins. Co.*, 363 F.3d 604, 606 & n.2 (6th Cir. 2004) (applying an unadulterated arbitrary and capricious standard of review to an insurer's claim denial, and suggesting that an inherent conflict will not alter the standard of review absent proof of actual impact on the decision under review). *See also Pitman v. Blue Cross & Blue Shield of Okla.*, 217 F.3d 1291, 1296 (10th Cir. 2000); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388-89 (3d Cir. 2000); *Vega v. Nat'l Life Ins. Servs., Inc.*, 188 F.3d 287, 295 n.7 (5th Cir. 1999) (en banc);

Doe v. Group Hospitalization & Med. Servs., 3 F.3d 80, 86 (4th Cir. 1993); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1563 (11th Cir. 1990).[4]

However, until the Tenth Circuit's decision in this case, even in those circuits that presume an actual conflict when an insurer is also a claim fiduciary, the presumption is rebuttable. If the insurer demonstrates that its role as payor did not in fact affect its denial of benefits, then an unmodified arbitrary and capricious standard of review is applied. As stated by the Third Circuit: "We do not, of course, pretend to establish an absolute, per se rule, recognizing that different relationships between the parties could effect a different result." *Pinto*, 214 F.3d at 388 n.6 (quoting *Metro. Life Ins. Co. v. Potter*, 992 F. Supp. 717 (D.N.J. 1998), as case where insurer's inherent conflict was "'lessened, if not eliminated'" by plan's premium structure). Similarly, the Eleventh Circuit allows an insurer to "prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Brown*, 898 F.2d at 1566; *see also Vega*, 188 F.3d at 295; *cf.*, *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997) (an insurer's inherent conflict is "greatly mitigated" where the insurer relies on an IME).

Only the Tenth Circuit, by adopting an absolute rule that applies to all insurer fiduciaries without regard to the existence or absence of actual bias, renders the presumption of an actual conflict irrebuttable.

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[4] There is a similar divide on how to treat an *employer's* dual status as funding source and claim fiduciary under a self-funded plan. *Compare, e.g., Salley v. E.I. DuPont de Nemours & Co.*, 966 F.2d 1011, 1014 (5th Cir. 1992) (assuming actual conflict based merely on fact that "DuPont funds the Plan from current operating revenues, giving it an apparent incentive to deny benefits"), *with Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (declining to presume actual conflict based on employer's dual roles because "[t]he impact on a company's welfare of granting or denying benefits under a plan will not be sufficiently significant as to threaten the administrators' partiality [*sic*]").

B. The Impact of a Conflict Under *Firestone*.

The courts of appeals have taken three basic, but again very different, approaches to evaluating the impact of insurers' structural conflicts on the standard of review of ERISA benefits denials: (1) A sliding-scale analysis; (2) a presumptively-void analysis; and (3) a de novo analysis.

Sliding-scale approach. The First, Third, Fourth, Fifth, Sixth, Seventh, and Eighth Circuits apply some version of a sliding-scale approach, under which the reviewing court applies an arbitrary and capricious standard of review, but "integrate[s] conflicts as factors in applying that standard, approximately calibrating the intensity of [the] review to the intensity of the conflict." *Pinto*, 214 F.3d at 393. "The greater the evidence of conflict on the part of the administrator, the less deferential [the] abuse of discretion standard will be." *Vega*, 188 F.3d at 297; *see also Pari-Fasano v. ITT Hartford Life & Acc. Ins. Co.*, 230 F.3d 415, 419 (1st Cir. 2000); *Woo*, 144 F.3d at 1161-62; *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 380 n.3 (7th Cir. 1994); *Doe v. Group Hospitalization*, 3 F.3d at 87; *Miller*, 925 F.2d at 984.[5]

Until the instant case, the Tenth Circuit also had approved the use of a sliding scale to "decrease the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict." *Chambers*, 100 F.3d at 825. In *Chambers*, the court "conclude[d] that the sliding scale approach more closely adheres to the Supreme Court's

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[5] In cases where the conflict is not deemed severe, application of the sliding-scale approach does not warrant a significant departure from a pure arbitrary and capricious standard, under which review is limited to determining whether the fiduciary's decision was reasonable and made in good faith, not whether it was the best or only "right" decision. *See, e.g.*, *Vega*, 188 F.3d at 301 (applying "only a modicum less deference than we otherwise would," where plaintiffs "demonstrated the minimal basis for a conflict [*i.e.*, the insurer's dual roles]," but "no evidence with respect to the degree of the conflict").

instruction to treat a conflict of interest as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* at 826 (quoting *Firestone*, 489 U.S. at 115); *see also, e.g.*, *Nance v. Sun Life Assur. Co. of Can.*, 294 F.3d 1263, 1269 (10th Cir. 2002); *McGraw v. Prudential Ins. Co. of Am.*, 137 F.3d 1253, 1258 (10th Cir. 1998).

Presumptively-void approach. The Ninth and Eleventh Circuits apply a presumptively-void approach: If "a plan beneficiary demonstrates a substantial conflict of interest . . . the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Brown*, 898 F.2d at 1566; *see also Atwood*, 45 F.3d at 1323; *but see* Melissa Grant, *Battling for ERISA Benefits in the Ninth Circuit: Overcoming Abuse of Discretion Review*, S.W.U. L. Rev. 93, 129 (1998) ("[t]he Ninth Circuit approach to allegations of conflicts of interests in ERISA benefits disputes has been inconsistent[,]" with different panels employing sliding scale and presumptively void tests). If the fiduciary does not carry its burden of proof, the court applies de novo review—even where the plan vests the insurer-fiduciary with discretion. *See, e.g.*, *HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 995 (11th Cir. 2001); *Atwood*, 45 F.3d at 1323.

De novo review approach. The Second Circuit requires strict proof that a conflict actually influenced the administrator's decision, *see supra* at 11, but once the actual conflict is established, the court applies de novo review—affording no deference at all to the conflicted fiduciary's determination. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1256 (2d Cir. 1996) (employer-fiduciary); *see also Whitney*, 106 F.3d at 477 (applying *Sullivan* analysis to insurer-fiduciary). The Eighth Circuit also has applied de novo review where the conflict is sufficiently "egregious." *Schatz v. Mut. of Omaha Ins. Co.*, 220 F.3d 944, 947 n.5 (8th Cir. 2000).

To this already-existing variety of approaches to an insurer-fiduciary's structural conflict of interest, the Tenth Circuit has added a wholly new analysis. Though purporting to merely "elaborate more fully" on its earlier articulation of the sliding scale approach, App. 12a, the court in fact discarded that authority. Now, under the decision below, reviewing courts no longer may cogently evaluate the unique facts of a case and "calibrate the reduced deference to the level of actual conflict that exists." *Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 2005 (10th Cir. 2002). The court has forced all insurer-fiduciaries into a rigid box, in which the burden of proof automatically shifts to the insurer to prove that its denial was supported by substantial evidence. In so doing, the Tenth Circuit has adopted the very approach expressly rejected in *Chambers* and by other courts applying a sliding scale: That "a decision rendered by a conflicted plan administrator is presumed to be arbitrary and capricious." *Chambers*, 100 F.3d at 826.

C. The Need for Clarification.

The lower courts have left no doubt that when the Court broached the subject of conflicts in *Firestone*, it did not clarify the issue but instead perplexed courts and litigants. "Since *Firestone*, courts have struggled to give effect to this delphic statement [the single sentence], and to determine both what constitutes a conflict of interest and how a conflict should affect the scrutiny of an administrator's decision to deny benefits." *Pinto*, 214 F.3d at 383; *see also Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1138 (11th Cir. 2004) ("Supreme Court decisions have not explained" the meaning of heightened arbitrary and capricious review); *Pinto*, 214 F.3d at 393 ("[O]nly the Supreme Court can undo the legacy of *Firestone*."); *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993) (noting criticisms of *Firestone* analysis of standard of review for structurally-conflicted fiduciaries exercising discretionary authority, and ob-

serving that "[p]erhaps the Supreme Court will have an opportunity to reconsider this issue").

As the en banc Fifth Circuit stated in 1999, "[i]n the [ten-year] interim since [*Firestone*], our Circuit has struggled with the appropriate standard of review for determinations by a self-interested administrator with discretionary authority," and "[o]ther Circuits have also struggled with the role a conflict of interest should play in determining whether an administrator has abused its discretion." *Vega*, 188 F.3d at 296 (citations omitted). *See also Doe v. Travelers*, 167 F.3d at 57 ("What constitutes a conflict and how the factor is to be weighed were not explained [in *Firestone*], and naturally the cases in the lower courts are now somewhat divided.") (footnote omitted); *Chambers*, 100 F.3d at 825-26 (noting conflict in circuits); *Buttram v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896, 900 n.6 (8th Cir. 1996) (same).[6]

Scholarly commentators also have emphasized the questions left unanswered in *Firestone*, the resultant conflicts in the circuits, and the need for answers from this Court. *See, e.g.*, Kevin Walker Beatty, *A Decade of Confusion: The Standard of Review for ERISA Benefit Denial Claims as Established by Firestone*, 51 Ala. L. Rev. 733, 750-51 (2000) (noting "the confusion among the circuit courts on key issues concerning the *Firestone* standard's application," which "chills uniformity of jurisprudence, one of ERISA's primary

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[6] During oral argument in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), members of the Court inquired extensively about the post-*Firestone* treatment of fiduciary conflicts under ERISA. *See* 2003 WL 21006122, at **5-14, 21-23, 25-27 (transcript of April 28, 2003 argument). Counsel for all parties confirmed the split among the circuits concerning when an actual conflict exists and how it affects review of a fiduciary's discretionary decisions. *Id.* at **6, 21-22, 25. However, the sole issue in *Black & Decker* was the validity of a treating-physician rule under ERISA, and the Court's decision does not address the conflict issue.

goals"); Nola A. Kohler, Note, *An Overview of the Inconsistency Among the Circuits Concerning the Conflict of Interest Analysis Applied in an ERISA Action with an Emphasis on the Eighth Circuit's Adoption of the Sliding Scale Analysis in Woo v. Deluxe Corporation*, 75 N.D. L. Rev. 815, 822 & n.76 (1999) ("Since *Firestone*, the federal courts have grappled with the appropriate analysis for such situations without further guidance from the Supreme Court. The lack of any clear direction from the Supreme Court has generated inconsistency among the circuits . . . ."); John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 S. Ct. Rev. 207, 208 (1990) ("[T]he Supreme Court in [*Firestone*] dealt with the problem so awkwardly that . . . [t]here is reason to think that . . . the Court will have to face the question anew.") ("Langbein").[7]

II. THE TENTH CIRCUIT'S DECISION CONFLICTS WITH *FIRESTONE*.

While the Court left critical questions unanswered in *Firestone*, leading to the conflicts summarized above, it confirmed that a fundamental purpose of ERISA is "'to protect contractually defined benefits.'" 489 U.S. at 113 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)). Consistent with that purpose and "established principles of trust law," "the benefit plan" must be the starting point for determining the scope of the fiduciary's authority. *Firestone*, 489 U.S. at 115. Therefore, "regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest," *id.*, the standard of

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[7] Ironically, the primary source for the Tenth Circuit's contribution to the confused state of the law begins its analysis by decrying "the conflicts plaguing the circuits." Kennedy, 50 Am. U. L. Rev. at 1086. "These differences among the circuits have made it increasingly difficult to administer plans in a consistent fashion, despite ERISA's intent to present a uniform set of rules applicable to employee benefit plans." *Id.*

review must depend primarily on the intent of the contracting parties as stated in the plan. Where "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," courts *must* apply an arbitrary and capricious standard of review. *Id.* Where a plan grants discretionary authority to actually conflicted fiduciaries, deferential review still applies but the conflict should be "weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (citation omitted). In reaching these conclusions, the Court rejected the approach of the Third Circuit, which had looked only to the status of the plan administrator, not to the plan itself:

> The Court of Appeals held that where an employer is itself the fiduciary and administrator of an unfunded benefit plan, . . . deference is unwarranted given the lack of assurance of impartiality on the part of the employer . . . . Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, we need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries.

Id. at 107-08, 115 (citations omitted).

The Tenth Circuit's decision in this case cannot be reconciled with these holdings in *Firestone*. The court of appeals' "inherent conflict" analysis makes presumed partiality the sole criterion for selecting the standard of review, rather than just one of several relevant factors under trust law—just as the Third Circuit erroneously did in *Firestone*. The Tenth Circuit's shifted burden analysis—which creates a presumption of wrongdoing that the fiduciary must rebut—renders the terms of the controlling plan documents virtually meaningless.[8]

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[8] The Court's consideration of conflicts in *Pegram v. Herdrich*, 530 U.S. 211 (2000), further highlights the defects in the Tenth Circuit's pre-

The Tenth Circuit's presumption of actual partiality also conflicts with ERISA itself. Congress expressly authorized employers to provide insurance benefits (*e.g.*, life, health, and disability benefits) to employees. *See* 29 U.S.C. § 1002(1) (2000) (defining an employee welfare benefit plan as a plan that provides one or more specified types of benefits "through the purchase of insurance or otherwise"). Despite ERISA's comprehensive prohibitions on conflicts of interest, *see* 29 U.S.C. §§ 1106-1107 (2000), the statute permits employers and insurers to serve as fiduciaries. *Id.* § 1108(c)(3); *see* Langbein, 1990 S. Ct. Rev. at 213 (discussing "ERISA's authorization of nonneutral fiduciaries"). Because service as a fiduciary necessarily requires the exercise of discretion, *see id.* § 1002(21)(A), Congress intended insurer-fiduciaries to exercise discretion. Yet, the Tenth Circuit's decision, in abolishing traditional arbitrary and capricious review of insurers' benefits determinations, tramples on that congressional intent.

III. THE APPROPRIATE STANDARD OF REVIEW FOR INSURER FIDUCIARIES EXERCISING DISCRETIONARY AUTHORITY IS A RECURRING ISSUE OF NATIONAL IMPORTANCE TO CLAIMANTS, EMPLOYERS, AND FIDUCIARIES.

The interest in uniformity. In enacting ERISA, Congress sought to foster a "uniformity of decision" to "help ad-

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sumed conflict analysis. In *Pegram*, the Court acknowledged the inherent financial conflict for HMO physicians who often receive profit-sharing incentives to ration care and, therefore, whose "financial interest lies in providing less care, not more." *Id.* at 219. Yet, the Court further recognized that "[t]he check on this influence . . . is the [doctor's] professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest." *Id.* Here, there is a similar check on the apparent conflict that insurers confront when they also serve as plan fiduciaries, *i.e.*, the very fact that they *are* fiduciaries who would face exposure under ERISA for proven self-dealing in violation of their fiduciary responsibilities.

ministrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws." S. Rep. No. 93-127, at 29 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4848, 4865. Congress wanted to "ensure that plans and plan sponsors would be subject to a uniform body of benefits law" so as to "minimize the administrative and financial burden of complying with conflicting directives," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)—"burdens ultimately borne by the [plan's] beneficiaries." *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001). However, "[u]niformity is impossible" if different courts subject plans to "different legal obligations." *Id.* at 148. *See also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) ("uniform administrative scheme" intended under ERISA would be "difficult to achieve" if a plan were required "to process claims in a certain way in some States but not in others").[9]

The vast divisions in the circuit court decisions described above defeat Congress' goal of uniformity. Uncertainty regarding the law breeds litigation. Absent review by this Court, the Tenth Circuit's decision will lead to even more forum-shopping under ERISA's liberal venue provision, which permits the filing of suit to recover benefits "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2) (2000).[10] And it will be inequitable to

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[9] The cited cases all considered the need for uniform law in the context of preemption under ERISA of varying state laws. The underlying interest in uniformity, however, applies equally to the federal courts' application of the Act.

[10] The courts have construed the "may be found" language as providing for venue in any district in which the defendant has minimum contacts sufficient to establish personal jurisdiction. *See I.A.M. Nat'l Pension Fund, Benefit Plan A v. Wakefield Indus., Inc.*, 699 F.2d 1254, 1257-58 (D.C. Cir. 1983); *Varsic v. United States Dist. Court for the Central Dist. of Cal.*, 607 F.2d 245, 248 (9th Cir. 1979).

employers, participants, and fiduciaries in different federal circuits.

In short, only a ruling by this Court can provide the uniformity that Congress intended to establish by enacting ERISA and that is now so obviously lacking.

The interest in encouraging ERISA plans. A prime purpose underlying ERISA was to encourage the formation of employee benefit plans, including disability plans. *See* 29 U.S.C. § 1001(a) (2000) (employee benefit plans "have become an important factor affecting the stability of employment and the successful development of industrial relations"). Nevertheless, provision of welfare and retirement benefits is voluntary: "Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Well aware of this freedom, Congress cautioned that plans should not be so heavily burdened by regulation that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 93-807, at 15 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4682. *See also Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (recognizing Congress' "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place") (citations omitted).

The Tenth Circuit's decision, by irrebuttably presuming an actual conflict and requiring insurer fiduciaries to defend every claim denial in a civil action, will foment appeals and, hence, will create a new and costly litigation burden that will raise the costs of plan administration. As insurers' costs needlessly rise—based on knee-jerk assumptions rather than actual evidence of bias—so employers' costs will increase, too. Inevitably, some employers will either reduce their plans' coverage or decline to offer those benefits at all. Ei-

ther result runs directly contrary to "the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). Again, even the Tenth Circuit's primary authority acknowledges this inevitable by-product of the court's unduly harsh approach:

> If all that is needed is proof of a potential or actual conflict of interest, there is little to lose in challenging a benefits denial case . . . . For small-and-medium-sized employers, the costs of litigation will increase the administrative costs of the plan, making it even more difficult to sponsor and maintain. This result is obviously in conflict with the initial purpose of ERISA to continue the growth and development of privately-sponsored employee benefit plans.

Kennedy, 50 Am. U. L. Rev. at 1088, 1162 (footnote omitted); *see also Vega*, 188 F.3d at 298 (en banc Fifth Circuit recognizing that a burden-shifting approach "would also violate basic principles of judicial economy").

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted, and the judgment of the Tenth Circuit reversed.

Respectfully submitted,

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